TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VIBRA HOSPITAL OF AMARILLO

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-18-0067-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The health care provider did not submit a position statement for review.

Amount in Dispute: $30,326.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is no DWC adopted fee guideline for long term care hospital services. Texas Mutual has a methodology that produces a fair and reasonable payment consistent with the requirements of the Labor Code at 413.011(d) and Rule 134.1(f)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2016 to January 19, 2017	Long-Term Care Hospital (LTCH) Inpatient Services	$30,326.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the division's *Hospital Facility Fee Guideline—Inpatient*.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 240 – PLEASE NOTE: TMI HAS NO RECORD DATES 1/13/17 THROUGH 1/19/17 WERE PREAUTHORIZED.
   - P5 – BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWABLE DEFINED BY LEGISLATED FEE ARRANGEMENT.

- 197 – PRECERTIFICATION/AUTHORIZATION NOTIFICATION ABSENT.
- 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
- 217 – THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE
- 240 – PREAUTHORIZATION NOT OBTAINED.
- 426 – REIMBURSED TO FAIR AND REASONABLE.

Issues

1. Did the requestor fail to obtain preauthorization for the disputed services?
2. What is the applicable rule for determining reimbursement of long-term care hospital services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied certain disputed services with claim adjustment reason codes:

   240 – "PREAUTHORIZATION NOT OBTAINED" and 197 – "PRECERTIFICATION/AUTHORIZATION NOTIFICATION ABSENT."

   The insurance carrier issued payment on the medical bill pursuant to a rate the respondent asserts is fair and reasonable reimbursement for the services in dispute. The above denial reason was not maintained at MFDR and is not mentioned or asserted in the respondent's position statement; therefore the division finds that there are no outstanding issues regarding preauthorization for the disputed services.

2. This dispute involves payment for hospital services provided by a long-term care facility. The requestor asserts that the applicable rule for reimbursement is 28 Texas Administrative Code §134.404, the division's *Hospital Facility Fee Guideline—Inpatient*, which, per Rule §134.404(a)(1), is applicable to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.

   Rule §134.404(b)(1) defines "acute care hospital" to mean:

   > a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

   Review of information available to the division as well as records held by the Texas Department of State Health Services finds that the requestor, VIBRA Hospital of Amarillo, is not a licensed acute care hospital. The NPI number listed in box 56 of the medical bill identifies the medical provider as a long term care hospital. The division has not established a medical fee guideline for long term care hospitals.

   Review of the submitted information finds no documentation to support a negotiated contract or that the services were provided through a workers' compensation health care network. Payment is therefore subject to the general medical reimbursement provisions of 28 Texas Administrative Code §134.1(e), which requires that, in the absence of an applicable fee guideline or a negotiated contract, medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with a fair and reasonable reimbursement amount as specified in Rule §134.1(f).

   In the following analysis, the evidence presented by both parties to support or refute each other's positions as to the fair and reasonable payment amount is examined in order to determine which party presents the best evidence of an amount that will achieve a fair and reasonable reimbursement for the services in dispute.

   The requestor has the burden of proof. The standard of proof required is by a preponderance of the evidence.

3. 28 Texas Administrative Code §134.1(f) requires that:

> Fair and reasonable reimbursement shall:
> (1) be consistent with the criteria of Labor Code §413.011;
> (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
> (3) be based on nationally recognized published studies, published division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

The Texas Supreme Court has summarized the statutory standards and criteria applicable to "fair and reasonable" fee determinations as requiring "methodologies that determine fair and reasonable medical fees, ensure quality medical care to injured workers, and achieve effective cost control." *Texas Workers' Compensation Commission v. Patient Advocates of Texas*, 136 *South Western Reporter Third* 643, 656 (Texas 2004). Additionally, the Third Court of Appeals has held, in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96, 104 (Texas Appeals – Austin 2003, petition for review denied), that "[E]ach . . . reimbursement should be evaluated according to [Texas Labor Code] section 413.011(d)'s definition of 'fair and reasonable' fee guidelines as implemented by Rule 134.1 for case-by-case determinations."

Texas Labor Code §413.011(d) requires that:

> Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) requires the requestor to provide:

> documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) . . . when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable

The division first reviews the information presented by the requestor to determine whether it has met the burden to show that the payment amount it is seeking is a fair and reasonable rate of reimbursement for the services in dispute. If the requestor's evidence is persuasive, then the division will review the respondent's evidence.

Review of the submitted documentation finds that:

- The requestor asks for payment according to the Medicare Inpatient Prospective Payment System formula multiplied by 143%.
- The requestor is not an acute care hospital, but rather a long-term care hospital (or LTCH).
- Payment cannot be calculated using the Medicare IPPS formula.
- The requestor did not explain or provide documentation to support why an economic adjustment factor of 143% should apply to LTCH services.
- The requestor did not explain or provided documentation to support how the proposed methodology ensures quality medical care to injured workers.
- The requestor did not explain or provided documentation to support how the proposed methodology achieves effective medical cost control.
- The requestor did not explain or provided documentation to support how the proposed methodology ensures that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not explain or provided documentation to support that the proposed methodology is consistent with the criteria of Labor Code §413.011.
- The requestor did not explain or provided documentation to support that the proposed methodology satisfies the requirements of Rule §134.1.

The request for additional reimbursement is not supported. After thorough review of the submitted information, the division concludes the requestor has failed to discuss, demonstrate, and justify that the payment amount sought is a fair and reasonable rate of reimbursement for the services in dispute. Consequently, additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

The applicable rule for determining reimbursement of the disputed long-term care hospital services is 28 Texas Administrative Code §134.1, regarding a fair and reasonable reimbursement.

For the reasons stated above, the Division finds the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 28, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.